TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
West Houston Medical Center

Respondent Name
American Zurich Insurance Co

MFDR Tracking Number
M4-16-3052-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
June 6, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "In closing, it is the position of the Hospital that all charges relating to the admission of this claimant are due and payable and not subject to the improper reductions taken by the Carrier in this case."

Amount in Dispute: $1,455.45

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Coventry is standing by the pricing."

Response Submitted by: Coventry

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 2, 2015	Outpatient Hospital Services	$1,455.45	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for outpatient hospital services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
   - P12

- 193

The services in dispute are for outpatient hospital services and are therefore subject to the requirements of 28 Texas Administrative Code 134.403 (d) which states in pertinent part, "For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided..." The applicable Medicare payment policy may be found at www.cms.gov.

In order to calculate the correct Division fee guideline, stakeholders should be familiar with the main components in the calculation of the Medicare payment for OPPS services which are:

1. **How payment rates are set –** found at www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/HospitalOutpaysysfctsht.pdf. *To account for geographic differences in input prices, the labor portion of the national unadjusted payment rate (60 percent) is further adjusted by the hospital wage index for the area where payment is being made. The remaining 40 percent is not adjusted.*
2. **Payment status indicator** - The status indicator identifies whether the service described by the HCPCS code is paid under the OPPS and if so, whether payment is made separately or packaged. The status indicator may also provide additional information about how the code is paid under the OPPS or under another payment system or fee schedule. The relevant status indicator may be found at the following: www.cms.gov, Hospital Outpatient Prospective Payment – Final Rule, OPPS Addenda, Addendum D1.
3. **APC payment groups** - Each HCPCS code for which separate payment is made under the OPPS is assigned to an ambulatory payment classification (APC) group. The payment rate and coinsurance amount calculated for an APC apply to all of the services assigned to the APC. A hospital may receive a number of APC payments for the services furnished to a patient on a single day; however, multiple surgical procedures furnished on the same day are subject to discounting. The relevant payment amount for each APC may be found at: www.cms.gov, Addendum B. These files are updated quarterly.
4. **Composite APCs** - Composite APCs provide a single payment for a comprehensive diagnostic and/or treatment service that is defined, for purposes of the APC, as a service typically reported with multiple HCPCS codes. When HCPCS codes that meet the criteria for payment of the composite APC are billed on the same date of service, CMS makes a single payment for all of the codes as a whole, rather than paying individually for each code.

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the rule applicable to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier reduced the submitted charges in dispute with claim adjustment reason code 97 – "The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated." Review of the submitted medical claim finds the following:

    - Procedure code J0690 has status indicator N denoting packaged items and services with no separate APC payment.
    - Procedure code J3490 has status indicator N denoting packaged items and services with no separate APC payment.
    - Procedure code J7030 has status indicator N denoting packaged items and services with no separate APC payment.
    - Procedure code G0431 has status indicator N denoting packaged items and services with no separate APC payment.

- Procedure code 80048 has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code 85027 has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code 73130 has status indicator Q1 denoting STVX-packaged codes; payment for these services is packaged into the payment for any other procedures with status indicators S, T, V, or X performed on the same date. Based on submitted medical claim code 96374 has a status indicator of "S". Therefore this is a packaged service.
- Procedure code G0378 has status indicator N denoting packaged items and services with no separate APC payment.

Pursuant to 28 Texas Administrative Code §134.203(d) which states in pertinent part, "apply Medicare payment policies in effect on the date a service is provided" the insurance carrier's denial reason is supported. Additional reimbursement cannot be recommended for these services in dispute.

2. Based on the Status Indicator of the remaining services in dispute, the MAR is calculated per 28 Texas Administrative Code 134.403 (f) which states,

> The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.
>
> (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
>
> (A) 200 percent;

Based on the APC of the remaining services in dispute, the MAR is calculated below:

Submitted code	Status Indicator	Multiple Procedure Discounting	APC	Payment Rate	Unadjusted labor amount = APC payment x 60%	Geographically adjusted labor amount = unadjusted labor amount x annual wage index	Non labor portion = APC payment rate x 40%	Medicare facility specific reimbursement (geographically adjusted labor) amount + non labor portion)	Maximum Allowable Reimbursement
96374	S	No	0438	$108.24	$108.24 x 60% = $64.94	$64.94 x 0.9679 = $62.86	$108.24 x 40% = $43.30	$62.86 + $43.30 = $106.16	$106.16 x 200% = $212.32
99285	Q3 – Composite criteria not met	No	0616	$492.69	$492.69 x 60% = $295.61	$295.61 x 0.9679 = $286.12	$492.69 x 40% = $197.08	$286.12 + $197.08 = $483.20	$483.20 x 200% = $966.40
									$1,178.72

3. Pursuant to applicable Division fee guidelines the maximum allowable reimbursement is $1,178.72. No additional payment is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		July 20, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.